ROBERT J. THOMPSON, Ph.D.
Clinical Psychologist

PATIENT INFORMATION FORM

Today's date: _____

1. Name: _____
2. What do you prefer me to call you:_____
3. Date of birth: _____ Age: _____
4. Birth place: _____
5. Day phone: _____ Evening phone: _____
6. Employer & occupation:_____
7. If married, spouse's name & age:_____How long married:_____
8. Previously married?, How often, how long: _____
9. Children, names and ages:

_____

_____

_____

10. Who referred you for psychological services: _____
11. Who is your personal physician: _____
12. Do you have concerns about your physical health? YES NO
13. Are you on any medications now? YES NO
    If YES, what medication & how much; _____
14. Do you have a long-term physical illness or handicap? YES NO
15. Have you ever received counseling or therapy? YES NO
16. Have you ever been psychologically evaluated? YES NO
17. Have you ever seriously thought about or attempted suicide? YES NO
18. Is there mental illness or substance abuse in your extended family? YES NO

19. Do you drink alcohol or use recreational drugs? YES NO
    If so, how often, and in what amounts?

20. Do you have a history of drug or alcohol abuse? YES NO

21. Do you have any problems with alcohol or drugs? YES NO

22. Does anyone close to you have problems with drinking or drugs? YES NO

23. Have you ever been admitted to a psychiatric hospital? YES NO

24. Do you have a history of problems with the law? YES NO

25. Were you separated from your parents as a child? YES NO

26. Were you abused as a child (physically, sexually, or mentally)? YES NO

27. What is your educational level? _____

28. How satisfied are you with your job?

    Satisfied In-between Dissatisfied

29. How satisfied are you with family relationships?

    Satisfied In-between Dissatisfied

30. How satisfied are you with your relationships with friends?

    Satisfied In-between Dissatisfied

31. How satisfied are your level and amount of recreation?

    Satisfied In-between Dissatisfied

32. Is religion an important part of your life?

    If yes, denomination: _____

33. What are the main stresses in your life?

    _____

34. If you have received previous mental health treatment or hospitalization, please list when and

35. where: _____

36. What other information should I know in order to best assist your treatment?

    _____

PATIENT REGISTRATION

LEGAL NAME _____
First Last Middle Initial

Address _____ Apt. # _____

City_____ State _____ Zip _____e-mail_____

Home Phone _____ Work Phone _____Employer _____

Birth Date _____/_____/_____ Sex [ ]M [ ]F

Check one: [ ]Single [ ]Married [ ]Separated [ ]Divorced [ ]Widowed

Patient's Primary Care Physician (PCP) _____

Name of person who referred you to Dr. Thompson _____

Person not living at your address to contact in case of emergency:

_____
Name Phone Relationship

PRIMARY INSURANCE

Subscriber _____/____/_____
Subscriber Birth Date Relationship to Patient

Insurance Company:_____Insurance Phone Number:_____

Claim Address:_____

ID #_____Group #_____ Effective Date _____/_____/_____

Employer _____

SECONDARY INSURANCE

Subscriber _____/____/_____
Subscriber Birth Date Relationship to Patient

Insurance Company:_____Insurance Phone Number:_____

Claim Address:_____

ID #_____Group #_____ Effective Date _____/_____/_____

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CONSENT TO TREATMENT

I have read, understood, and agree to these policies and procedures, including my rights confidentiality and its exceptions.

I hereby authorize Robert J. Thompson, Ph.D. and/or his billing service to release any medical/psychological information necessary to process claims with any insurance company. I also assign Robert J. Thompson, Ph.D. all payments to which I am entitled for medical expenses. I understand that my portion of payment is due at the time of service and that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

- ❑ I have checked into preauthorization and insurance requirements and benefits for mental health services.

I give my consent to treatment and/or the treatment of my child.

_____
Signature

_____
Name of Patient

_____

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Receipt and Acknowledgment of Notice of Privacy Practices and Service Agreement

Patient Name:_____

I have received and have been given an opportunity to read a copy of Dr. Thompson's Notice of Privacy Practices. I understand that if I have any questions regarding my privacy rights, I can contact Dr. Thompson.

_____

Signature of Patient, Parent or Guardian Date

- ❑ Patient, Parent or Guardian Refuses to Acknowledge Receipt of Privacy Practices Agreement
- ❑ Date:_____